United States Department of Labor
Employees' Compensation Appeals Board

J.P., Appellant	)	
and	)	**Docket No. 15-0599**
	)	**Issued: June 7, 2016**
U.S. POSTAL SERVICE, POST OFFICE, Swedesboro, NJ, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On January 26, 2015 appellant, through counsel, filed a timely appeal from a November 5, 2014 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether OWCP properly terminated appellant's wage-loss compensation and medical benefits effective March 27, 2014 as she no longer had any residual disability causally related to her accepted employment-related injury.

FACTUAL HISTORY

On February 4, 2004 appellant, then a 30-year-old mail processing clerk, filed an occupational disease claim alleging that the repetitive routine of her position caused or

[1] 5 U.S.C. § 8101 *et seq.*

aggravated her right lateral epicondylitis and medial epicondylitis conditions. OWCP initially accepted the condition of lateral epicondylitis and later expanded the claim to include the conditions of brachial plexus right arm, right radial nerve lesion, right brachial neuritis or radiculitis, right styloid tenosynovitis, and other lesion of right median nerve.[2]

Appellant filed a separate claim (claim number xxxxxx811) which was accepted for right lateral epicondylitis.[3] She returned to work with limitations but stopped all work on June 12, 2006 and did not return. OWCP retained appellant on the periodic compensation rolls.

Appellant was initially treated by Dr. Nadine Rosenthal, a Board-certified internist, and Dr. Thomas Stackhouse, a Board-certified orthopedic surgeon, for lateral epicondylitis and radial tunnel syndrome of the right arm. Later in 2005 she came under the care of Dr. Scott Fried, a Board-certified orthopedic surgeon, for right forearm lateral epicondylitis with radial tunnel, repetitive right strain injury with flexor tenosynovitis, right medial neuropathy, and probable proximal early radiculitis. Appellant also received injections from Dr. Steven M. Rosen, a Board-certified anesthesiologist.

Appellant continued to treat with Dr. Fried and he continued to opine that appellant had residuals of her accepted work-related conditions.

On February 2, 2010 appellant was referred to Dr. Franklin Draper, Jr., a Board-certified orthopedic surgeon, for a second opinion examination. In a report dated March 4, 2010, Dr. Draper reviewed her examination findings and concluded that her work-related conditions had improved, but had not resolved. He concluded that appellant could work part time, with restrictions. In a supplemental report dated July 14, 2010, Dr. Draper related that he had reviewed additional evidence, including a March 18, 2010 functional capacity evaluation, and DVD video surveillance of appellant from March 28 through April 10, 2009. He concluded that, based upon his review of all of the evidence, she could work eight hours a day with restrictions regarding repetitive use of the upper extremities.

OWCP found a conflict in medical evidence between Dr. Fried and Dr. Draper with regard to whether she had continuing disability due to her accepted conditions.

By letter dated August 2, 2010, appellant was referred to Dr. David A. Bundens, a Board-certified orthopedic surgeon, for an impartial medical examination. Counsel for appellant, by letter dated August 11, 2010, requested a copy of the statement of accepted facts (SOAF) and a copy of the referral letter to the physician, as well as the medical report. In a report dated August 17, 2010, Dr. Bundens stated that he had conducted a physical examination and had reviewed her extensive medical records, as well as the surveillance video. He concluded that

[2] OWCP paid medical and wage-loss compensation benefits, including authorization for a right radial nerve decompression on April 10, 2007 and anterior submuscular transposition of the right ulnar nerve on May 10, 2011, right C7 and C8 transforaminal injections on August 7, 2012, right C6 and C7 transforaminal injections on September 4, 2012, and right stellate ganglion injection on October 16, 2012.

[3] This claim was combined under the current claim with the current claim as the master file.

appellant could work full time, with restrictions. Dr. Bundens also concluded that proposed right cubital tunnel surgery was reasonable and work related.

By letter dated September 13, 2010, OWCP provided counsel a copy of Dr. Bundens' report, along with the SOAF.

Following her May 10, 2011 right ulnar nerve transposition surgery, appellant underwent a functional capacity evaluation on June 11, 2012. In a report dated July 16, 2012, Dr. Fried related that he had reviewed the functional capacity evaluation and noted significantly increased symptoms with repetitive upper extremity activity. Therefore he recommended permanent job restrictions and retraining for a new occupation.

On July 19, 2012 OWCP referred appellant to Dr. Stanley Askin, a Board-certified orthopedic surgeon, acting as a second opinion examiner for OWCP. In his August 3, 2012 report, Dr. Askin noted the history of injury and appellant's treatment, listed his findings on examination and concluded that the accepted conditions were no longer active or causing her current symptoms. He diagnosed carpal tunnel syndrome which he opined was not causally related to her employment as she had not worked in six years. Dr. Askin opined that appellant could work her date-of-injury position with no limitations even with her nonindustrial carpal tunnel syndrome. In a supplemental report of September 27, 2012, he elaborated on his opinion that there was no causal relationship between appellant's carpal tunnel syndrome and her work duties or the accepted work-related conditions. Dr. Askin stated that carpal tunnel syndrome was the most common peripheral neuropathy and was fairly endemic around the middle aged, especially females. He advised that this condition occurred secondary to thickening of the membranes surrounding the flexor tendon, which compresses the median nerve. Dr. Askin noted that appellant's pathological studies had not documented inflammation which should be present if this was an overuse type of condition. He again noted that she had not worked for a significant block of time and this supported the finding that her carpal tunnel syndrome was not work related.

In an investigative report of November 5, 2012, the employing establishment's Office of Inspector General noted that appellant had been under surveillance from April 20 to December 26, 2009 and from December 26, 2011 to October 19, 2012 and reported on its findings. It verified that appellant had been performing various activities using both upper extremities.

Dr. Fried continued to support that appellant had residuals of the upper extremity conditions which prevented her from returning to her regular job.

Appellant was advised of a referral to Dr. Askin for another second opinion examination. Counsel requested, by letter dated February 12, 2013, a copy of the SOAF and a copy of the report.

In a February 15, 2013 report, Dr. Askin reevaluated appellant and reviewed the surveillance videotapes of appellant's activities. He discussed his findings on examination and concluded that there was no diagnosis of a condition at the present time related to the accepted work-related injury. Dr. Askin opined that appellant could return to work in her regular position

with no restrictions and completed a work capacity evaluation indicating such. He continued to opine that she had no work-related residuals and the bilateral carpal tunnel condition was nonindustrial.

By letter dated February 20, 2013, counsel was provided a copy of the SOAF and the questions asked of Dr. Askin.

OWCP continued to receive reports from Dr. Fried and Dr. Rosen, which opined that appellant's conditions were work related.

Following a March 5, 2013 notice of proposed termination, OWCP received additional reports from Dr. Rosen opining that appellant's condition was work related. On March 18, 2013 appellant's counsel advised OWCP that it had not yet received a copy of Dr. Askin's February 15, 2013 report. By letter dated April 5, 2013 a copy of the record was provided to counsel by OWCP.

By decision dated April 8, 2013, OWCP terminated appellant's wage-loss compensation and medical benefits effective that day, finding that the weight of the medical opinion evidence rested with Dr. Askin's opinion that appellant no longer had residuals of the accepted work-related conditions.

On July 25, 2013 the employing establishment advised that appellant had been removed from his employment for improper conduct based on their investigation. Appellant had admitted to misrepresenting her condition by omitting pertinent information to her physicians.

Appellant requested a hearing before an OWCP hearing representative, which was held by video on August 22, 2013. She disputed the termination of benefits explaining that she continued to have residuals of the accepted work injury. During the hearing, the surveillance video was discussed and appellant testified that she had looked at the investigative video and the report. She contended that the video showed her lifting most often with her left hand, not her injured right hand. Appellant acknowledged that she could have been carrying a bag of bananas with her right hand. She believed that much of the video evidence misrepresented the truth.

Several medical reports were received from Dr. Fried and Dr. Rosen discussing appellant's limitations and although they believed she continued to have residuals of the accepted conditions, they acknowledged that she could work with restrictions. In an April 8, 2013 report, Dr. Rosen discussed appellant's treatment since July 17, 2012. He opined that she continued to have a brachial plexus injury, which was a repetitive nerve injury, and noted examination findings of pain and tenderness with no motor or sensory changes and normal reflexes. Dr. Rosen stated that, while appellant was capable of performing activities of daily living, those activities would increase her symptoms.

In a March 19, 2013 report, Dr. Fried diagnosed flexor tenosynovitis right, flexor tenosynovitis left, carpal tunnel median neuropathy (repetitive strain injury), bilateral upper extremities, right radial neuropathy, brachial plexopathy/cervical radiculopathy, bilateral carpal tunnel median neuropathy which he opined were secondary to work activities. He opined that appellant remained symptomatic from those work injuries and could not return to her previous level of activity or work duties.

In a May 7, 2013 report, Dr. Rosen indicated that appellant had persistent neck, shoulder and arm pain and noted examination findings. He opined that she suffered from a brachial plexus injury and was symptomatic. In an October 17, 2013 report, Dr. Fried noted positive findings on examination, which included positive Phalen's and Tinel's testing, spasms in the upper trapezius area bilaterally, and positive Roos and Hunter tests. He opined that appellant continued to have residuals of the accepted conditions but that she could work with modifications.

By decision dated November 12, 2013, an OWCP hearing representative affirmed the April 8, 2013 termination decision as it was correct at the time it was issued. It found, however, that, following the decision, additional medical evidence was received from Dr. Fried which listed objective findings on examination, including positive Tinel's of the ulnar nerve of the right elbow, spasms, and positive Roos and Hunter testing at the elbow for thoracic outlet or brachial plexus injury, which created a conflict in medical opinion with Dr. Askin as to whether appellant continued to have residuals of the accepted work-related condition. The hearing representative directed that an updated SOAF be prepared which listed the physical requirements of appellant's date-of-injury position, as well as a list of the accepted conditions. This SOAF was to be provided to an impartial medical specialist with a copy of the entire file, including the video surveillance evidence for review and comment.

OWCP referred appellant, along with a December 3, 2013 statement of accepted facts, list of questions, and the medical record, to Dr. Gregory S. Maslow, a Board-certified orthopedic surgeon, for an impartial medical evaluation. On January 7, 2013 appellant's counsel requested proof that Dr. Maslow had been properly selected, a copy of the SOAF and the letter to the physician, as well as a copy of the report.

In a February 10, 2014 report, Dr. Maslow noted the history of injury, his review of the statement of accepted facts, and appellant's medical record. He then set forth examination findings. Dr. Maslow found no palpable or visible cervical neck muscular spasm. In looking for radicular signs and symptoms, he did a vertex compression test which did not show evidence of abnormality. In evaluating thoracic outlet syndrome signs or symptoms, Dr. Maslow did an overhead exercise testing and found it negative on left and right sides. The Adson's maneuver was also negative left and right. Dr. Maslow was unable to find tenderness in either the supraclavicular or infraclavicular region at either shoulder. The shoulder girdle examination was normal on left side, but the right shoulder showed tenderness both in the supraclavicular and infraclavicular regions, but no Tinel's over the brachial plexus. There was full range of motion in all planes at the shoulder with no bony shoulder girdle tenderness and no shoulder instability or crepitus. There was also negative O'Brien testing. Dr. Maslow noted excellent strength testing of the cuff with no biceps tendinopathy or impingement. Appellant had full shrug strength testing with no atrophy, spasm or droop in the musculature. The left upper extremity examination had normal elbow examination with full supination/pronation. On the right side, the elbow examination showed well-healed scars with no tenderness over the scars and full range of motion with no instability, crepitus, synovitis, or tenderness over either the medial or lateral epicondyle or over the olecranon region or at the radiocapitellar joint. There was full supination/pronation without pain complaint.

Regarding the alleged carpal tunnel syndrome, Dr. Maslow found that the wrist showed full range of motion in all planes bilaterally with no synovitis at either wrists or tendinitis or synovitis. There was also no crepitus, no tenderness at the snuffbox, no tenderness at de Quervain's point, and no tenderness over the ulnar carpal articulation. Tendon function was intact in both hands with normal color and temperature of the skin. A positive wrist compression test was noted on the left side with positive Tinel's at the right wrist and positive Phalen's test. A diminished pinch grip was noted on the right side with the rest of the examination normal. Dr. Maslow concurred with Dr. Askin's opinion that the bilateral carpal tunnel syndrome apparent on his examination was not work related. He stated that appellant had not worked in many years and there was no indication that the carpal tunnel syndrome would prohibit her return to her previous employment and there was no evidence on examination that any of the other diagnoses, which had been tendered by her physicians, were present or would interfere with return to the previous employment.

Dr. Maslow opined that appellant was capable of full-duty, full-time work without restrictions due to the accepted work-related conditions. He further opined that the carpal tunnel syndrome was not causally related to work-related activities and would not prohibit her from returning to employment. Dr. Maslow noted that his review of the surveillance tapes confirmed his opinions.

On February 24, 2014 OWCP again proposed to terminate appellant's wage-loss compensation and medical benefits as there were no longer any residuals or continuing disability from the accepted work-related medical conditions. Special weight was accorded to Dr. Maslow's impartial medical opinion. Appellant was afforded 30 days to submit additional evidence or argument.

In response, appellant's counsel argued Dr. Maslow's report lacked sufficient detail to establish resolution of the accepted conditions. He noted that Dr. Maslow failed to address positive electrodiagnostic studies supporting the conditions.

In a March 6, 2014 letter to Dr. Maslow, OWCP noted that additional medical rationale was needed to support his conclusions. It also asked him to identify the objective testing used and to comment on the current diagnostic testing of record. In a March 13, 2014 addendum report, Dr. Maslow noted that he had performed a neurologic examination of the upper extremities which included specific testing for peripheral nerve impingement and entrapment, namely Tinel's and Phalen's testing, as well as a strength testing examination. He stated that there was normal strength testing, normal intrinsic function, and a normal sensory examination. Dr. Maslow included the fact that there was no atrophy, which was an important factor in this matter. He indicated that appellant's range of motion at the elbows and wrists were normal and provided measurements. Dr. Maslow stated that the only way to measure atrophy in the hand was visualization at the thenar eminence and appellant had no atrophy in the interosseous or in the thenar or hypothenar regions in either hand. He stated that, while appellant's on-the-job repetitive work may have caused carpal tunnel syndrome, she did not initially complain of it or be judged by her physicians to have it. It was only after a prolonged period of time that a diagnosis of carpal tunnel syndrome was made. Dr. Maslow opined that there was no evidence that appellant suffered carpal tunnel syndrome at either extremity as a result of on-the-job activity. He noted that her carpal tunnel syndrome was 70 percent idiopathic.

By decision dated March 27, 2014, OWCP terminated appellant's wage-loss compensation and medical benefits effective March 27, 2014. Special weight was accorded to Dr. Maslow's reports.

On April 2, 2014 OWCP received appellant's request for an oral hearing, which was held on August 15, 2014. Appellant's counsel presented arguments against Dr. Maslow's opinion carrying the weight of the evidence.

In a March 24, 2014 letter, Dr. Fried summarized examination findings of appellant over the years of treatment. He last examined her on May 2, 2013. Dr. Fried reviewed Dr. Maslow's February 10, 2014 report and noted his disagreement, arguing that both clinical and diagnostic evidence supported the continuance of every accepted condition and that she was capable of sedentary, nonrepetitive type of work. In forming his opinions, Dr. Fried noted that he had not seen any surveillance videos of appellant and that he relied upon her representations of the evidence.

By decision dated November 5, 2014, an OWCP hearing representative affirmed OWCP's March 27, 2014 decision finding that appellant no longer had any residuals of the accepted work-related conditions.

LEGAL PRECEDENT

Once OWCP accepts a claim, it has the burden of justifying termination or modification of compensation. After it has been determined that an employee has disability causally related to her employment, OWCP may not terminate compensation without establishing that the disability had ceased or that it was no longer related to the employment.[4] OWCP's burden of proof includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[5] Furthermore, the right to medical benefits for an accepted condition is not limited to the period of entitlement for disability. To terminate authorization for medical treatment, OWCP must establish that a claimant no longer has residuals of an employment-related condition that requires further medical treatment.[6]

Section 8123(a) of FECA provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[7] The implementing regulations state that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination. This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior

[4] *Jason C. Armstrong*, 40 ECAB 907 (1989).

[5] *See Del K. Rykert*, 40 ECAB 284, 295-96 (1988).

[6] *Mary A. Lowe*, 52 ECAB 223 (2001); *Wiley Richey*, 49 ECAB 166 (1997).

[7] 5 U.S.C. § 8123(a).

connection with the case.[8] In situations where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[9]

ANALYSIS

OWCP accepted that appellant sustained right lateral epicondylitis, right brachial plexus injury, right radial nerve lesion, right median nerve lesion and right styloid tenosynovitis as a result of her employment and paid benefits, including surgical procedures of April 10, 2007 and May 10, 2011. Appellant stopped work on June 12, 2006 and was eventually retained on OWCP's periodic compensation rolls. OWCP terminated her wage-loss compensation and medical benefits on March 27, 2014 based on the reports of Dr. Maslow, the impartial medical specialist. By decision dated November 5, 2014, an OWCP hearing representative affirmed OWCP's March 27, 2014 termination decision. The Board finds that OWCP met its burden of proof.

OWCP properly referred appellant to Dr. Maslow for an impartial medical examination to resolve the conflict in medical opinion evidence, pursuant to 5 U.S.C. § 8123(a). In reports dated August 3 and September 27, 2012, and February 15, 2013, Dr. Askin, an OWCP second opinion physician, opined that the accepted conditions were no longer active or disabling. He found no objective findings on examination to support residuals of the accepted work-related conditions and the activities demonstrated during video surveillance negated continued residuals. Dr. Askin further diagnosed bilateral carpal tunnel syndrome which he opined was not causally related to either her work duties or the accepted work-related conditions. He indicated that appellant could return to work with no restrictions.

In his October 17, 2013 report, Dr. Fried, appellant's treating physician, noted positive findings on examination, which included positive Phalen's and Tinel's testing, spasms in the upper trapezius area bilaterally, and positive Roos and Hunter tests. He opined that appellant continued to have residuals of the accepted conditions and concluded that she could work with modifications. Dr. Fried's opinion was of sufficient probative value to create a conflict with Dr. Askin's opinion. While Dr. Rosen also submitted reports, his reports lacked detailed examination findings or an opinion on causation.

The Board finds that OWCP met its burden of proof to terminate appellant's medical and wage-loss compensation benefits based on the February 10 and March 13, 2014 reports of Dr. Maslow, who accurately summarized her medical history, reviewed an updated statement of accepted facts, viewed the surveillance video, and examined appellant finding no objective evidence to support ongoing employment-related residuals or disability due to the accepted conditions of right lateral epicondylitis, right brachial plexus injury, right radial nerve lesion, right median nerve lesion and right styloid tenosynovitis.

[8] 20 C.F.R. § 10.321.

[9] *Gloria J. Godfrey*, 52 ECAB 486 (2001); *Jacqueline Brasch (Ronald Brasch)*, 52 ECAB 252 (2001).

In his February 10, 2014 report, Dr. Maslow conducted a neurologic examination of the upper extremities, which was essentially normal with no findings of atrophy. He concurred with Dr. Askin's opinion that the bilateral carpal tunnel syndrome apparent on his examination was not work related. Dr. Maslow stated that appellant had not worked in many years and there was no indication that the carpal tunnel syndrome would prohibit her return to her previous employment. There was also no evidence on examination that any of the other diagnoses were present or would interfere with return to the previous employment. Dr. Maslow opined that appellant was capable of full duty, full-time work without restrictions imposed by the previously accepted work-related diagnoses. A review of the surveillance tapes confirmed his opinions.

In his March 13, 2014 addendum report, Dr. Maslow explained that he had performed a neurologic examination of the upper extremities and included specific testing for peripheral nerve impingement and entrapment, including Tinel's and Phalen's testing, along with strength testing examination. He stated that there was no atrophy, which is an important factor in this case, and there was normal strength testing, normal intrinsic function and a normal sensory examination. Dr. Maslow noted range of motion was normal, and provided findings at the elbows and wrists. He indicated that the only way to measure atrophy in the hand was visualization at the thenar eminence and appellant had no atrophy in the interosseous or in the thenar or hypothenar regions in either hand.

Dr. Maslow stated that there was no evidence that she suffered carpal tunnel syndrome at either extremity as a result of on-the-job activity. He concluded that the carpal tunnel syndrome was not causally related to work-related activities and would not prohibit her from returning to employment.

The Board finds that Dr. Maslow's reports are well rationalized and based on a complete and accurate history, a complete statement of accepted facts and the entire case record, including surveillance videos. Dr. Maslow examined appellant thoroughly, reviewed the medical records, and reported accurate medical and employment histories and reviewed the surveillance video of appellant. Thus, his opinion that the accepted conditions have resolved without residuals is entitled to special weight.[10]

The additional medical evidence submitted in response to Dr. Maslow's report is insufficient to overcome the weight accorded to him as an impartial medical specialist regarding this issue. While Dr. Fried submitted a March 24, 2014 report arguing that the clinical and diagnostic evidence supported the continuance of every allowed condition and that the bilateral carpal tunnel condition was casually related to appellant's work duties, he had been on one side of the conflict in medical opinion regarding whether there were any residuals of the employment-related conditions and whether they were disabling. Reports from a physician who was on one side of a medical conflict that an impartial medical specialist resolved, are generally insufficient to overcome the weight accorded to the opinion of the impartial physician or to create a new conflict.[11]

[10] *See Bryan O. Crane*, 56 ECAB 713 (2005).

[11] *Jaja K. Asaramo*, 55 ECAB 200 (2004).

Regarding the request to expand the claim to accept the recently diagnosed bilateral carpal tunnel syndrome, Dr. Fried did not provide the necessary medical rationale to accept that this condition was causally related to appellant's work duties. A mere conclusion without the necessary medical rationale to explain how and why the physician believes that appellant's accepted exposure could result in a diagnosed condition is not sufficient to meet her burden of proof. The medical evidence must also include rationale explaining how the physician reached the conclusion he or she is supporting, which Dr. Fried failed to do.[12] OWCP has not accepted a bilateral carpal tunnel condition and appellant bears the burden of proof to establish that the condition is causally related to specified conditions of employment. Causal relationship is a medical issue and the medical evidence required to establish a causal relationship is rationalized medical evidence.[13] Dr. Fried has not explained how, physiologically, appellant would have sustained carpal tunnel syndrome, from the work activities she ceased years ago. Accordingly, his report is insufficient to cause a new conflict with Dr. Maslow.

Therefore, the Board finds that OWCP properly terminated appellant's wage-loss and medical compensation benefits effective March 27, 2014, as the weight of the competent medical evidence established that the accepted conditions of right lateral epicondylitis, right brachial plexus injury, right radial nerve lesion, right median nerve lesion, and right styloid tenosynovitis had resolved without residuals.

On appeal, counsel contends that Dr. Maslow's reports are insufficiently rationalized and not based upon proper examination to be entitled to special weight. For the reasons enunciated above, Dr. Maslow's reports are entitled to special weight in this case.

Appellant may submit evidence or argument with a written request for reconsideration within one year of this merit decision pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that OWCP met its burden of proof to terminate appellant's compensation benefits effective March 27, 2014 as she no longer had any residual disability causally related to her accepted January 15, 2004 employment-related injuries.

[12] *See T.M.*, Docket No. 08-975 (issued February 6, 2009) (a medical report is of limited probative value on the issue of causal relationship if it contains a conclusion regarding causal relationship which is unsupported by medical rationale).

[13] *Paul Foster*, 56 ECAB 208 (2004); *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

ORDER

IT IS HEREBY ORDERED THAT the November 5, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 7, 2016
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board